

§1523. Filing Requirement

A. The filing and prior approval of forms containing an accelerated benefit is required.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

Chapter 17. Regulation 456 Filing of Affirmative Action Plans

§1701. Purpose

A. The purpose of this regulation is to implement R.S. 22:1923 A.(1), which requires an insurer to file an affirmative action plan upon the violation of a cease and desist order issued by the commissioner after hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923 A.(1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

§1703. Applicability and Scope

A. This regulation applies to any insurer that is called for hearing before the commissioner for violating Part X of the Insurance Code (Equal Opportunity In Insurance) and found to be in violation of a Cease and Desist Order issued in accordance with the provisions of R.S. 22:1923 A. It sets forth the minimum content and procedures for the filing of an affirmative action plan by an insurer who violates Part X of the Insurance Code, and who then violates a cease and desist order issued by the commissioner after hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923 A.(1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

§1705. Content and Procedure

A. The commissioner shall notify an insurer of its violation of a cease and desist order issued pursuant to Part X of the Insurance Code by Certified U.S. Mail, return receipt requested. Said notification shall also direct the insurer to file an affirmative action plan.

B. The notice shall require the insurer to file its plan within 20 days of receipt of the notice.

C. The insurer shall file its plan by means of the U.S. Mail, and it shall contain the minimum requirements stated in R.S. 22:1923 C.(4)(a) and (b).

D. The insurer shall address the plan to the attention of the Office of Minority Affairs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923 A.(1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

§1707. Effective Date

A. This regulation shall become effective upon final promulgation in the *Louisiana Register*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923 A.(1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

Chapter 19. Regulation 466 Long-Term Care Insurance

§1901. Purpose

A. The purpose of this regulation is to implement R.S. 22:1731-1737, Long-Term Care Insurance Act, to promote the public interest; to promote the availability of long-term care insurance coverage; to protect applicants for qualified and nonqualified long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices; to facilitate public understanding and comparison of long-term care insurance coverages; and to facilitate flexibility and innovation in the development of long-term care insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1903. Applicability and Scope

A. Except as otherwise specifically provided, this regulation applies to all long-term care insurance policies [or certificate issued pursuant to such group policy] delivered, or issued for delivery, in this state on or after the effective date hereof, by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations; and all similar organizations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1905. Definitions

A. For the purpose of this regulation, the terms Applicant, Certificate, Commissioner, Group Long-Term Care Insurance, Long-Term Care Insurance, Policy, Qualified Long-Term Care Insurance Contract and Qualified Long-Term Care Services shall have the following meanings:

Applicant

a. in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

b. in the case of a group long-term care insurance policy, the proposed certificate holder.

Certificate for the purposes of this regulation, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

Commissioner the Insurance commissioner of this state.

Group Long-Term Care Insurance a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

a. one or more employers or labor organizations; or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof; for employees or former employees or a combination thereof; or for members or former members, or a combination thereof, of the labor organizations; or

b. any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

i. is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

ii. has been maintained in good faith for purposes other than obtaining insurance; or

c.i. an association or a trust or the trustee(s) of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws which provide that:

(a). the association or associations hold regular meetings not less than annually to further purposes of the members;

(b). except for credit unions, the association or associations collect dues or solicit contributions from members; and

(c). the members have voting privileges and representation on the governing board and committees.

ii. Thirty days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the commissioner makes a finding that the association or associations does not satisfy those organizational requirements.

d. a group, other than as described in subparagraphs a.-c of this paragraph on group long term care insurance, subject to a finding by the commissioner that:

i. the issuance of the group policy is not contrary to the best interest of the public;

ii. the issuance of the group policy would result in economies of acquisition or administration; and

iii. the benefits are reasonable in relation to the premiums charged.

Long-Term Care Insurance

a. any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital.

b. such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Such term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations; or any similar organizations to the extent they are otherwise authorized to issue life or health insurance.

c. long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

d. with regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

e. notwithstanding any other provision contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions set forth in ' 1953 of this regulation.

Policy for the purposes of this regulation, any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Qualified Long-Term Care Insurance Contract

a. any individual or group insurance contract, if it meets the requirements of Section 7702(B) of the *Internal Revenue Code*, as amended, and if:

i. the only insurance protection provided under the contract is coverage of qualified long-term care services;

ii. the contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this Paragraph do not apply to contracts where Medicare is a secondary payor, or where the contract makes per diem or other periodic payments without regard to expenses;

iii. the contract is guaranteed renewable;

iv. the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed. All refunds of premiums, and all policyholder dividends or similar amounts under such contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund of the aggregate premium paid under the contract may be allowed in the event of death of the insured or a complete surrender or cancellation of the contract; and

v. the contract contains the consumer protection provisions set forth in Section 7702(B)(g) of the *Internal Revenue Code*.

b. *Qualified Long-Term Care Insurance Contract* any life insurance contract which provides long-term care coverage by rider, or as part of the contract, as long as the contract complies with the applicable provisions of Section 7702(B) of the *Internal Revenue Code*, as amended.

Qualified Long-Term Care Services necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services to which an insured is eligible for under a qualified long-term care insurance contract, and which are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1907. Policy Definitions

A. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

Activities of Daily Living at least bathing, continence, dressing, eating, toileting, and transferring.

Acute Condition that the individual is medically unstable. Such an individual requires frequent monitoring

by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

C. Adult Day Care a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Bathing washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Cognitive Impairment a deficiency in a person's short or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Continence the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

Eating feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by feeding tube or intravenously.

Hands-On Assistance physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

Home Health Care Services medical and nonmedical services provided to ill, disabled, or infirmed persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.

Medicare "the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted, and any later amendments or substitutes thereof," or words of similar import.

Mental or Nervous Disorder shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

Personal Care the provision of hands-on services to assist an individual with activities of daily living.

Skilled Nursing Care, Intermediate Care, Personal Care, Home Care and other services shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.

Toileting getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring moving into or out of a bed, chair, or wheelchair.

All providers of services including, but not limited to, *Skilled Nursing Facility, Extended Care Facility, Intermediate Care Facility, Convalescent Nursing Home, Personal Care Facility, and Home Care Agency* shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1909. Policy Practices and Provisions

A. Unless otherwise noted, all provisions of ' 1909 shall also apply to qualified long-term care insurance contracts.

1. Renewability. The terms *guaranteed renewable* and *noncancellable* shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of ' 1915 of this regulation.

a. No such policy issued to an individual shall contain renewal provisions other than *guaranteed renewable* or *noncancellable*.

b. The term *guaranteed renewable* may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

c. The term *noncancellable* may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums, during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

d. A qualified long-term insurance contract must be guaranteed renewable.

2. Limitations and Exclusions. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

- a. preexisting conditions or diseases;
- b. mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

c. alcoholism and drug addiction;

d. illness, treatment, or medical condition arising out of:

- i. war or act of war (whether declared or undeclared);
- ii. participation in a felony, riot, or insurrection;
- iii. service in the armed forces or units auxiliary thereto;
- iv. suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or
- v. aviation (this exclusion applies only to non-fare-paying passengers).

e. treatment provided in a government facility (unless otherwise required by law); services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability, or occupational disease law, or any motor vehicle no-fault law; services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;

f. section 1909.A.2 is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

3. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization, if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

4. Continuation or Conversion

a. Group long-term care insurance issued in this state on or after the effective date of ' 1909 shall provide covered individuals with a basis for continuation or conversion of coverage.

b. For the purposes of ' 1909, *a basis for continuation of coverage* means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium, when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans including, but not limited to, provider system arrangements,

service availability, benefit levels, and administrative complexity.

c. For the purposes of ' 1909, *a basis for conversion of coverage* means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

d. For the purposes of ' 1909, *converted policy* means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

e. Written application for the converted policy shall be made, and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

g. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

i. termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

ii. the terminating coverage is replaced not later than 31 days after termination by group coverage effective on the day following the termination of coverage:

(a). providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(b). the premium for which is calculated in a manner consistent with the requirements of ' 1909.A.4.f.

h. Notwithstanding any other provision of ' 1909, a converted policy issued to an individual who, at the time of conversion, is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

i. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

j. Notwithstanding any other provision of ' 1909, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

k. For the purposes of ' 1909, a *managed-care plan* is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks.

5. Discontinuance and Replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

a. shall not result in any exclusion for pre-existing conditions that would have been covered under the group policy being replaced; and

b. shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

6. Premium Rate Filing

a. An issuer of any contract of long-term care insurance in this state shall file annually, for informational purposes, its rates, rating schedule, and such supporting documentation as necessary to identify the type of long-term care insurance as either qualified or nonqualified, the corresponding policy form number, the percentage(s) of rate adjustments, and the rating methodology.

b. All filings described in ' 1909 shall be submitted to the commissioner by March 31 of each calendar year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1911. Unintentional Lapse

A. Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following.

1. Notice Before Lapse or Termination

a. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium or a written waiver, dated and signed by the applicant, electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state:

"Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

b. The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.

c. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in ' 1911.A.1.a need not be met until 60 days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

d. Lapse or Termination for Nonpayment of Premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to ' 1911.A.1.a, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and

unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

C. Reinstatement. In addition to the requirement in ' 1911.A.1, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage, in the event of lapse, if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option shall be available to the insured, if requested within five months after termination, and shall allow for the collection of past due premium where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1913. Required Disclosure Provisions

A. Unless otherwise noted, all subsections of ' 1913 shall apply to qualified long-term care insurance contracts.

1. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

2. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made, in writing, by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to, in writing and signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider, or endorsement.

3. Payment of Benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as *usual and customary*, *reasonable and customary* or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

4. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Pre-existing Condition Limitations."

5. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility, other than those prohibited in R.S. 22:1736(D)(2), shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate Paragraph of the policy or certificate and shall label such Paragraph, "Limitations or Conditions on Eligibility for Benefits."

6. Disclosure of Tax Consequences. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider, and at the time the accelerated benefit payment request is submitted, that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. Section 1913.A.6 shall not apply to qualified long-term care contracts.

7. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate Paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in '1913. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

8. A qualified long-term care insurance contract must include a disclosure statement in the policy, and in the outline of coverage, that the policy is intended to be a qualified long-term care insurance contract.

a. [Policies that are not intended to be a qualified long-term care insurance contract must include a disclosure statement in the policy, and in the outline of coverage, that the policy is not intended to be a qualified long-term care insurance contract. The disclosure shall be prominently displayed, and shall read as follows:

This long-term care insurance policy (certificate) is not intended to be a qualified long-term care insurance contract. You need to be aware that benefits received under this policy may create unintended, adverse income tax consequences to you. You may want to consult with a knowledgeable individual about these potential income tax consequences.]

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1915. Prohibition Against Post-Claim Underwriting

A. All applications for long-term care insurance policies or certificates, except those which are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

B.1. If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

2. If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

C. Except for policies or certificates which are guaranteed issue:

1. the following language shall be set out conspicuously, and in close conjunction with the applicant's signature block, on an application for a long-term care insurance policy or certificate:

CAUTION: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy;

2. the following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

CAUTION: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address];

3. prior to issuance of a long-term care policy or certificate to an applicant age 80 or older, the insurer shall obtain one of the following:

- a. a report of a physical examination;
- b. an assessment of functional capacity;
- c. an attending physician's statement; or
- d. copies of medical records.

D. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate, unless it was retained by the applicant at the time of application.

E. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily

effectuated, and shall annually furnish this information to the Insurance commissioner in the format prescribed by the National Association of Insurance Commissioners in ' 1955.A.1, Appendix A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1917. Minimum Standards for Home Health and Community Care Benefits in Long-term Care Insurance Policies

A. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

1. by requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;
2. by requiring that the insured or claimant first, or simultaneously, receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;
3. by limiting eligible services to services provided by registered nurses or licensed practical nurses;
4. by requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;
5. by excluding coverage for personal care services provided by a home health aide;
6. by requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;
7. by requiring that the insured or claimant have an acute condition before home health care services are covered;
8. by limiting benefits to services provided by Medicare-certified agencies or providers;
9. by excluding coverage for adult day care services.

B. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

C. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1919. Requirements to Offer Inflation Protection

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

1. increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent;
2. guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status, so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or
3. covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the required offer in ' 1919.A shall be made to the group policyholder; except, if the policy is issued to a group defined in ' 1905 and R.S. 22:1734(4)(d), other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

C. The offer in ' 1919.A shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

D. Insurers shall include the following information in or with the outline of coverage:

1. a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period;
2. any expected premium increases or additional premiums to pay for automatic or optional benefit increases. An insurer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure.

E. Inflation protection benefit increases, under a policy which contains such benefits, shall continue without regard

to an insured's age, claim status, or claim history, or the length of time the person has been insured under the policy.

F. An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose, in a conspicuous manner, that the premium may change in the future, unless the premium is guaranteed to remain constant.

G.1. Inflation protection, as provided in ' 1919.A.1, shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection, signed by the policyholder, as required in.' 1919.G. In the case of a qualified long-term care insurance contract, the rejection may be either in the application or on a separate form.

2. The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1921. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group defined by ' 1905 and R.S. 22:1734(4)(a), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement.

1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?
2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?
 - a. If so, with which company?
 - b. If that policy lapsed, when did it lapse?
3. Are you covered by Medicaid?
4. Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

B. Agents shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.
2. List policies sold in the past five years which are no longer in force.

C. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant, and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR
LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

(Applicant's Signature)

(Date)

D. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND
SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. Your insurer will waive any time periods applicable to pre-existing conditions or

probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

E. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured, and policy number or address, including zip code. Such notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

F. In recommending the purchase or replacement of any long-term care insurance policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1923. Reporting Requirements

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percentage of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percentage of the agent's total annual sales.

B. Each insurer shall report annually, by June 30, the 10 percent of its agents with the greatest percentages of lapses and replacements, as measured by ' 1923.A.

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

D. Every insurer shall report annually, by June 30, the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year.

E. Every insurer shall report annually, by June 30, the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year.

F. Every insurer shall report annually, by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied, other than claims denied for failure to meet the waiting period or because of any applicable pre-existing condition.

G. For purposes of '1923, *policy* shall mean only long-term care insurance and *report* means on a statewide basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1925. Licensing

A. No agent is authorized to market, sell, solicit, or otherwise contact a person for the purpose of marketing long-term care insurance unless the agent has demonstrated his or her knowledge of long-term care insurance and the appropriateness of such insurance by passing a test required by this state and maintaining appropriate licenses.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1927. Discretionary Powers of Commissioner

A. The commissioner may, upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

1. the modification or suspension would be in the best interest of the insureds; and
2. the purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
- 3.a. the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
- b. the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
- c. the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1929. Reserve Standards

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with R.S. 22:162, R.S. 22:162.1. and R.S. 22:163. Claim reserves shall also be established in the case when the policy or rider is in claim status.

B. Reserves for policies and riders subject to '1929.B should be based on the multiple decrement model, utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the greater of the estimated loss portion of the premium for the long-term care component of coverage (as established in '1931) and the reserves for the life insurance benefit, assuming no long-term care benefit.

C.1. In the development and calculation of reserves for policies and riders subject to '1929.C, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs including, but not limited to, the following:

- a. definition of insured events;
- b. covered long-term care facilities;
- c. existence of home convalescence care coverage;
- d. definition of facilities;
- e. existence or absence of barriers to eligibility;
- f. premium waiver provision;
- g. renewability;
- h. ability to raise premiums;
- i. marketing method;
- j. underwriting procedures;
- k. claims adjustment procedures;
- l. waiting period;
- m. maximum benefit;
- n. availability of eligible facilities;
- o. margins in claim costs;
- p. optional nature of benefit;
- q. delay in eligibility for benefit;

- r. inflation protection provisions; and
- s. guaranteed insurability option.

2. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

D. When long-term care benefits are provided other than as in ' 1929.A, reserves shall be determined using a table established for reserve purposes by a qualified actuary and acceptable to the commissioner. However, in no event shall the reserves for the long-term care benefit be less than the estimated loss portion of the premium for such coverage (as established in ' 1931).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1931. Loss Ratio

A. Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums, provided the expected loss ratio is at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

1. statistical credibility of incurred claims experience and earned premiums;
2. the period for which rates are computed to provide coverage;
3. experienced and projected trends;
4. concentration of experience within early policy duration;
5. expected claim fluctuation;
6. experience refunds, adjustments, or dividends;
7. renewability features;
8. all appropriate expense factors;
9. interest;
10. experimental nature of the coverage;
11. policy reserves;
12. mix of business by risk classification; and
13. product features such as long elimination periods, high deductibles, and high maximum limits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1933. Filing Requirement

A. Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state,

pursuant to R.S. 22:1735, it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1935. Filing Requirements for Advertising

A. Every insurer, health care service plan, or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state, whether through written, radio, or television medium, to the commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three years from the date the advertisement was first used.

B. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1937. Standards for Marketing

A. Every insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

1. establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;
2. establish marketing procedures to assure excessive insurance is not sold or issued;
3. display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

NOTICE TO BUYER: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

4. inquire, and otherwise make every reasonable effort to identify, whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness, in the case of a qualified long-term care insurance contract, or long-term care insurance and the types and amounts of any such insurance;

5. establish auditable procedures for verifying compliance with ' 1937.A;

6. if the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program, approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that such a program is available and the name, address and telephone number of the program.

7. for long-term care health insurance policies and certificates, use the terms *noncancelable* or *level premium* only when the policy or certificate conforms to ' 1909.A.1.c of this regulation.

B. In addition to the practices prohibited in R.S. 22:1211 et seq., the following acts and practices are prohibited:

Cold Lead Advertising making use directly, or indirectly, of any method of marketing which fails to disclose, in a conspicuous manner, that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

High Pressure Tactics employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

Material Misrepresentation making, directly or indirectly, a representation which is false, upon which the insured substantially relies in deciding to purchase a policy.

Twisting knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

C.1. With respect to the obligations set forth in ' 1937.C.1, the primary responsibility of an association, as defined in ' 1905 and R.S. 22:1734(4)(b), when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues, in general, so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold. Section 1937.C.1 does not apply to qualified long-term care insurance contracts.

2. The insurer shall file with the Insurance Department the following material:

- a. the policy and certificate;
- b. a corresponding outline of coverage; and
- c. all advertisements requested by the Insurance Department.

3. The association shall disclose in any long-term care insurance solicitation:

- a. the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

- b. a brief description of the process under which the policies, and the insurer issuing the policies, were selected.

4. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

5. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

6. The association shall also:

- a. at the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance, not affiliated with the insurer, to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

- b. actively monitor the marketing efforts of the insurer and its agents; and

- c. review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

NOTE: Section 1937.C.6.a.-c shall not apply to qualified long-term care insurance contracts.

7. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state Insurance Department the information required in ' 1937.C.

8. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in ' 1937.C.

9. Failure to comply with the filing and certification requirements of ' 1937 constitutes an unfair trade practice in violation of R.S. 22:1211 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1939. Suitability

A. Section 1939 shall not apply to life insurance policies that accelerate benefits for long-term care.

B. Every insurer, health care service plan, or other entity marketing long-term care insurance (the *issuer*) shall:

1. develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
2. train its agents in the use of its suitability standards; and
3. maintain a copy of its suitability standards and make them available for inspection, upon request, by the commissioner.

C.1. To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

- a. the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
- b. the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
- c. the values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

2. The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in ' 1939.C.1. The efforts shall include presentation to the applicant at, or prior to, application the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in ' 1955.A.2, Appendix B, in not less than 12-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

3. A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

4. The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in ' 1955.A.2, Appendix B, is prohibited.

D. The issuer shall use the suitability standards it has developed, pursuant to ' 1939, in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

E. Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term

Care Insurance" shall be provided. The form shall be in the format contained in ' 1955.A.3, Appendix C, in not less than 12-point type.

G. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to ' 1955.A.4, Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

H. The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1941. Prohibition Against Pre-Existing Conditions and Probationary Periods in Replacement Policies or Certificates

A. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to pre-existing conditions and probationary periods in the new long-term care policy for similar benefits, to the extent that similar exclusions have been satisfied under the original policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1943. Nonforfeiture Benefit Requirement

A. No policy or certificate may be delivered, or issued for delivery, in this state unless the issuer of such contract of insurance offers to the policyholder or certificate holder a nonforfeiture benefit, as described in ' 1943. Section 1943 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

1. For purposes of ' 1943, *attained age rating* is defined as a schedule of premiums, starting from the issue date, which increases with increasing age at least 1 percent per year prior to age 50, and at least 3 percent per year beyond age 50.

2. For purposes of ' 1943, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse

but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in ' 1943.A.3.

3. The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of ' 1943.B.

4. No policy or certificate shall begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date, except that for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

- a. the end of the tenth year following the policy or certificate issue date; or
- b. the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

5. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

B. Nonforfeiture benefits in a qualified long-term care insurance contract shall:

- 1. be appropriately captioned;
- 2. provide that the amount of the benefit available in the event of a default in the payment of any premiums, and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest, as reflected in changes in rates for premium paying contracts approved by the secretary of the Treasury for the contract form; and
- 3. shall include at least one of the following:
 - a. reduced paid-up insurance;
 - b. extended term insurance;
 - c. shortened benefit period; or
 - d. other similar offerings approved by the secretary of the Treasury.

C. All benefits paid by the insurer while the policy or certificate is in premium paying status and the paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

D. There shall be no difference in the minimum nonforfeiture benefits, as required under ' 1943, for group and individual policies.

E. The requirements set forth in ' 1943 shall become effective 12 months after adoption of this provision and shall apply as follows.

1. Except as provided in ' 1943.E.2, the provisions of ' 1943 apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

2. For certificates issued on or after the effective date of ' 1943, under a group long-term care insurance policy, as defined in ' 1905.E.1 and R.S. 22:1734(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of ' 1943 shall not apply.

3. For qualified long-term care insurance contracts, the nonforfeiture provisions shall be effective on January 1, 1998.

F. Premiums charged for policy or certificate containing nonforfeiture benefits shall be subject to the loss ratio requirements of ' 1931 treating the policy as a whole.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1945. Standards for Benefit Triggers

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

B.1. Activities of daily living shall include at least the following as defined in ' 1907 and in the policy:

- a. bathing;
- b. continence;
- c. dressing;
- d. eating;
- e. toileting; and
- f. transferring.

2. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in ' 1945.B.1, as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in ' 1945.A.-B.

D. For purposes of ' 1945, the determination of a deficiency shall not be more restrictive than:

- 1. requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
- 2. if the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by

another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

F. Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

G. The requirements set forth in ' 1945 shall be effective January 1, 1999 and shall apply as follows:

1. Except as provided in ' 1945.G.2, the provisions of ' 1945 apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.

2. For certificates issued on or after the effective date of ' 1945, under a group long-term care insurance policy, as defined in ' 1905.E and R.S. 22:1734(4) that was in force at the time this amended regulation became effective, the provisions of ' 1945 shall not apply.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1947. Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts

A. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living for an expectation of at least 90 days due to a loss of functional capacity, as described in ' 1947.D.1; or severe cognitive impairment, as described in ' 1947.D.2. An insured will be considered to have met a condition of payment if, within the preceding 12-month period, a licensed health care practitioner has certified that the insured has met such requirements, and such practitioner has prescribed the qualified long-term care insurance services pursuant to a plan of care. Eligibility for the payment of benefits shall not be more restrictive than requiring a deficiency in the ability to perform not more than three of the activities of daily living.

B.1. Activities of daily living shall include the following, as defined in ' 1907 and in the qualified long-term care insurance contract:

- a. bathing;
- b. continence;
- c. dressing;
- d. eating;
- e. toileting; and
- f. transferring.

2. An issuer of qualified long-term care contracts is limited to considering only the activities of daily living listed in ' 1947.B.1.

C. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

D. For the purposes of ' 1947, determinations of functional capacity and severe cognitive impairment shall be based on the following standards:

1. for loss of functional capacity, requiring the substantial assistance of another person to perform the prescribed activities of daily living; or

2. for severe cognitive impairment, requiring substantial supervision including, but not limited to, verbal cueing by another person to protect the insured from harming him or herself [or others, or from threats to such individual's health or safety].

E. Qualified long-term care contracts shall include a clear description of the process for appealing and resolving benefit determinations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1949. Standard Format Outline of Coverage

A. Section 1949 of the regulation implements, interprets, and makes specific the provisions of R.S. 22:1736(G) in prescribing a standard format and the content of an outline of coverage.

B. The outline of coverage shall be a free-standing document, using no smaller than 10-point type.

C. The outline of coverage shall contain no material of an advertising nature.

D. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

E. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

F. Format for outline of coverage:

[COMPANY NAME]
[ADDRESS - CITY AND STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
[Policy Number or Group Master
Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

CAUTION: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed]

INSURANCE

[was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!**

3. **THIS PLAN IS INTENDED TO BE A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.** (For qualified long-term care insurance contracts, a disclosure statement must be included stating that it is the intention of this contract to be considered as such.)

4. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY.**

(2) [Policies and certificates that are noncancelable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELABLE.** This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions;]

(d) [State whether or not the company has a right to change premium, and if such right exists, describe clearly and concisely each circumstance under which premium may change.]

5. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.**

(a) [Provide a brief description of the right to return the "free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

6. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the *Medicare Supplement Buyer's Guide* available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

7. **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home. This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

8. **BENEFITS PROVIDED BY THIS POLICY.**

(a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Noninstitutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

9. **LIMITATIONS AND EXCLUSIONS.**

[Describe:

(a) Pre-existing conditions;

(b) Noneligible facilities and provider;

(c) Noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This Section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

**THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH
YOUR LONG-TERM CARE NEEDS.**

10. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

- (a) That the benefit level will not increase over time;
- (b) Any automatic benefit adjustment provisions;
- (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
- (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
- (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

11. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

12. PREMIUM

- [(a) State the total annual premium for the policy;
- (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

13. ADDITIONAL FEATURES

- [(a) Indicate if medical underwriting is used;
- (b) Describe other important features.]

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1951. Requirement to Deliver Shopper's Guide

A. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

1. In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

2. In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under R.S. 22:1736(J).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1953. Penalties

A. In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to \$10,000, whichever is greater.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

§1955. Effective Date

A. This regulation shall be effective on January 1, 1998.

1. Appendix A

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF LOUISIANA
FOR THE REPORTING YEAR 19[]

Company Name:

Address:

Phone Number:

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

INSURANCE

Policy Form Number	Policy and Certificate Number	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission
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☐ No change
 ☐ Increase
 ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7 percent of your income.

Savings and Investments

Not counting your home, what is the approximate value of all of your assets (savings and investments)? (check one)

☐ Under \$20,000
 ☐ \$20,000-\$30,000
 ☐ \$30,000-\$50,000

☐ Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same
 ☐ Increase
 ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

<input type="checkbox"/> The information provided above accurately describes my financial situation.	<input type="checkbox"/> I choose not to complete this information.
--	---

Signed: _____

(Applicant)
(Date)

[? I explained to the applicant the importance of completing this information.

Signed: _____

(Agent)
(Date)

Agent's Printed Name: _____

[Note: In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.

Signed: _____

(Applicant)
(Date)

The company may contact you to verify your answers.

3. Appendix C

THINGS YOU SHOULD KNOW BEFORE YOU BUY

LONG-TERM CARE INSURANCE

Detailed reason for rescission:

Signature

Name and Title (please type)

2. Appendix B

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

People buy long-term care insurance for a variety of reasons. These reasons include to avoid spending assets for long-term care, to make sure there are choices regarding the type of care received, to protect family members from having to pay for care, or to decrease the chances of going on Medicaid. However, long-term care insurance can be expensive, and is not appropriate for everyone. State law requires the insurance company to ask you to complete this worksheet to help you and the insurance company determine whether you should buy this policy.

Premium

The premium for the coverage you are considering will be [\$ _____ per month, or \$ _____ per year.] [a one-time single premium of \$ _____.]

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums in the future.] The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The last rate increase for this policy in this state was in [year], when premiums went up by an average of ____ percent]. [The company has not raised its rates for this policy.]

[? Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20 percent?]

Income

Where will you get the money to pay each year's premiums?

☐ Income
 ☐ Savings
 ☐ Family members

What is your annual income? (check one)

☐ Under \$10,000
 ☐ \$[10-20,000]
 ☐ \$[20-30,000]

☐ \$[30-50,000]
 ☐ Over \$50,000

How do you expect your income to change over the next 10 years? (check one)

- Long-Term Care Insurance ? A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- ? [You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]
- ? The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
- Medicare ? Medicare does not pay for most long-term care.
- Medicaid ? Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
- ? Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term services.
- ? When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- ? Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
- Shopper's Guide ? Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
- Counseling ? Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department on aging for more information about the senior health insurance counseling program in your state.

4. Appendix D

LONG-TERM CARE INSURANCE SUITABILITY LETTER

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us

to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

G Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage.
Please resume review of my application.

G No. I have decided not to buy a policy at this time.

Applicant Signature

Date

Please return to [issuer] at [address] by [date].

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1737.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997).

Chapter 21. Regulation 47C Actuarial Memoranda

§2101. Purpose

A. The purpose of this regulation is to prescribe:

1. guidelines and standards for statements of actuarial opinion which are to be submitted in accordance with R.S. 22:162.1 actuarial opinion reserves, and for memoranda in support thereof;

2. guidelines and standards for statements of actuarial opinion which are to be submitted when a company is exempt from R.S. 22:162.1 B, C; and

3. rules applicable to the appointment of an appointed actuary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:162.1.